Office Use Only: Epidemiologist: _____ County: _____Report Date: _____

CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

Heat Injury Reporting Form

Diagnosis (Please check one):

□**Heat Stroke** □**Heat Exhaustion** □**Heat Cramps** □ **Dehydration**

Patient Information

Patient Name: _____D.O.B _____Age _____

Address: _____
Street Address City State Zip County

Sex: Male □ Female □ Race/Ethnicity: _____ Did patient expire? Yes □ No □

Symptoms: *(Check all Applicable)*

Unconsciousness □ **Dizzy** □ **Confused** □ **Weak** □ **Pale** □

Dehydration □ **Cramps** □ **Exhaustion** □ **Rash** □ **Nausea** □ **Vomiting** □

Alcohol related heat injury? Yes □ **No** □ **Recreational related heat injury** □ **Work related heat injury** □

Heat injury onset date: _____ **Time heat injury occurred: _____a.m./p.m.**

Reporting Hospital Information

Facility Name: _____

Contact Person: _____ Ph # _____

Remarks:

_____
_____
_____
_____

Please fax a copy of this reporting form to:

210-207-8807

San Antonio Metropolitan Health District - Epidemiology
2509 Kennedy Circle, San Antonio, TX - 78235
Telephone: (210) 207-8876